



Informal Dispute Resolution (IDR)



(402) 471-6468
(Lincoln area & out-of-state)

Workers' Compensation Court
State of Nebraska
P. O. Box 98908
Lincoln, NE 68509-8908

(800) 599-5155
(Nebraska only)

Injured Employee:

Name: _____ Social Security #: _____
Address: _____ Phone #: () _____
_____ Fax #: () _____
Attorney if represented: _____ Phone #: _____ Fax #: () _____

Employer:

Contact Name: _____
Company: _____
Address: _____ Phone #: () _____
_____ Fax #: () _____
Attorney if represented: _____ Phone #: () _____ Fax #: () _____

Insurer:

Contact Name: _____
Company: _____
Address: _____ Phone #: () _____
_____ Fax #: () _____
Attorney if represented: _____ Phone #: () _____ Fax #: () _____

Nature of the dispute:

In order to prepare both parties, please answer as many of the following questions as possible that apply to the current situation. Write N/A in the blank to those questions that do not apply. Attach a written explanation in addition to the answers below if necessary. ***Please copy this form and any attachments and send to the court (attn: mediation coordinator) and to the other party(s). Send only copies of attachments. Originals will not be returned.*** Information not to be disclosed to the other party(s) may be sent to the court, but please indicate it is confidential. If you have any questions, please call the mediation coordinator.

1. What is the date(s) of injury(s)? _____ Attach a copy of the First Report(s) of Injury if available.

2. Has this dispute ever been submitted to the court? _____ If so, please give docket/page number: _____

3. Explain briefly how the accident or injury occurred.

4. Has the worker missed any time from work due to the injury? _____ If so, please specify days or parts of days.

5. Has the worker returned to work? _____ If so, state the type of work, date started, salary and whether it is with the same employer.
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6. If the worker hasn't returned to work, does he or she feel capable of returning to suitable and gainful employment with previous training and skills?
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7. Did a doctor prohibit the worker from working or request restricted or light duty? _____ **Attach a copy** of the note/report from the doctor if possible.
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8. What was the average weekly wage at the time of injury? _____
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9. Has a doctor stated that the worker is at "maximum medical improvement" or anything similar? _____ **Attach a copy** of the note/report from the doctor if possible.
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10. Has a doctor assigned an impairment rating or disability rating? _____ If so, what _____ % and part of body: _____ **Attach a copy** of the note/report from the doctor if possible.
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11. Has a Loss of Earning Power Evaluation been performed by any vocational rehabilitation counselor? _____ **Attach a copy** of the report if possible.
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12. Are there outstanding medical bills? _____ If so, please summarize on a one-page list and **attach copies** of each.
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13. Is the employee under a Managed Care Plan for workers' compensation? _____ If so, has the grievance procedure under the plan been exhausted?
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14. What has the employee and what has the employer or insurer paid for at this point? _____ Attach summary sheet if necessary.
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15. Are there any other people who will participate in the mediation conference with you? _____
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Issue(s) in dispute: Please explain in detail the issue(s) in dispute. If the insurer has denied the claim please attach a copy of the denial letter.

Desired outcome: List any specific action you would like taken. List any monetary amount you desire paid to you, or which you have already paid and the basis for this amount.

Signature

Date